(cut and return registration form only)

Medicaid Family Planning Waiver
Seminar and Teleconference Registration
(No Fee)

Provider Name _____ Provider Number _____

Address _____

City, Zip Code _____ County _____

Contact Person _____ E-mail Address _____

Telephone Number (_____)_____ Fax Number (_____)_____

I will attend the seminar at _____on _____
(location) (date)

Check the box to indicate the training session(s) you will be attending:

☐ Morning Session ☐ Afternoon Session

Return to: Provider Services
EDS
P.O. Box 300009
Raleigh, NC 27622